



**CENTERIOR
ENERGY**

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Perry Nuclear Power Plant
Docket No. 50-440
Response to Notice of Violation

Gentlemen:

This letter provides the Perry Nuclear Power Plant response to the Notice of Violation contained within NRC Inspection Report 50-440/94010 dated August 17, 1994. The report documented the results of the special announced team inspection conducted May 28 through July 6, 1994.

The response to the Notice of Violation is provided by Attachment 1. In addition, the letter transmitting the Notice of Violation requested additional information regarding radiation dose expenditures during the refueling outage. The requested information is included as Attachment 2.

If you have any questions or require additional information, please contact Mr. James D. Kloosterman, Manager - Regulatory Affairs at (216) 280-5833.

Very Truly Yours,

RAS:1kr:dhl

Attachments

cc: NRC Project Manager
NRC Resident Inspector
NRC Region III

200036

Operating Companies
Cleveland Electric Illuminating
Toledo Edison

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Response to Notice of Violation

50-440/94010-01

Restatement of the Violation

Technical Specification 6.8.1.a, requires that written procedures be established, implemented and maintained covering the activities recommended in Appendix A of Regulatory Guide (RG) 1.33, Revision 2, February 1978. RG 1.33 Appendix A, Item 4.e. recommends, in part, instructions for changing modes of operation of the shutdown cooling system. System operating instruction SOI-E12, "Residual Heat Removal System", subsection 4.5.3, step 5. requires verification that valve 1E12F064A is closed.

Contrary to the above, on June 21, 1994, at about 9:39 p.m., while shifting shutdown cooling loops using subsection 4.5.3, valve 1E12F064A was not verified to be closed.

Acceptance of the Violation

Cleveland Electric Illuminating Company accepts the violation as written.

Reason for the Violation

The reason for this violation is personnel error, failure to follow procedure.

During the evolution to shift shutdown cooling from residual heat removal (RHR) loop "B" to loop "A", a licensed operator opened the RHR "A" shutdown cooling suction valve (1E12F006A) with the minimum flow valve (1E12F064A) open, opening a siphon flow path from the vessel to the suppression pool. System operating instruction SOI-E12, "Residual Heat Removal System", subsection 4.5.3, step 5. requires verification that valve 1E12F064A is closed; this step was not performed by the licensed operator.

Personnel error, inattention to detail, contributed to this event in that while directly supervising the shift of shutdown cooling loops, the Unit Supervisor failed to observe that the 1E12F064A valve was open.

Corrective Action Taken and Results Achieved

Immediate corrective action for the event was to close the 1E12F006A suction valve and the 1E12F064A minimum flow valve, and to verify that reactor level did not decrease as a result of the event.

Additional corrective actions included counseling the licensed operator and the Unit Supervisor involved in the event, emphasizing the significance of the event and how better use of self checking techniques could have prevented the event. The licensed operator and the Unit Supervisor were also coached on proper performance of evolutions in a control room simulator coaching session.

Actions to Avoid Further Violations

Operations management discussed this event with the operating crews to emphasize the need for procedural compliance, the potential results of personnel errors resulting from failure to follow procedures, the relevance of self checking techniques to this event and the importance of consistent application of self checking techniques.

In addition licensed plant operators will receive training on this event as a part of requalification training. The training will be completed by January 15, 1995.

Date When Full Compliance Will Be Achieved

Full compliance was achieved at the completion of immediate corrective actions to close the 1E12F006A suction valve and the 1E12F064A minimum flow valve at the time of the event.

50-440/94010-13

Restatement of the Violation

Technical Specification 6.11.1, in part, requires that procedures for personnel radiation protection be adhered to for all operations involving personnel radiation exposure.

PAP-0512, "Radiation Work Permits," section 6.4.1.1.a, states, in part, that no RWP work may be performed while logged onto the access control RWP.

Contrary to the above, on June 22, 1994, while signed onto the access control RWP, a plant operator performed work in the overhead in the radiologically restricted area.

Acceptance of the Violation

Cleveland Electric Illuminating Company accepts the violation as written.

Reason for the Violation

The reason for this violation is personnel error, failure to follow procedure. Plant Administrative Procedure (PAP), Radiation Work Permit (RWP) Program, (PAP-0512) permits radiation workers to access the Radiologically Restricted Area (RRA) on the access control general RWP for activities not associated with specific or other general RWPs. PAP-0512 also indicates that radiation workers are responsible for recognizing that entry into a posted high radiation area requires an RWP which establishes required radiological controls for the activity. PAP-0512 further requires that radiation workers ensure an understanding of radiological conditions and radiological control requirements associated with assigned activities.

In addition, PAP-0511, Radiologically Restricted Areas, requires radiation workers to comply with the requirements associated with radiological postings, which include a valid RWP for high radiation areas and, in addition, prohibits

access to overhead areas in RRAs unless permitted by health physics personnel.

Contrary to the above, a plant operator inappropriately accessed a valve in an area of the RRA posted as a high radiation area. At the work location, the activity required accessing the overhead area. Although a high radiation area posting was provided for the general overhead area, the operator did not recognize that the posting applied to the specific assigned work location, did not recognize the applicability of the PAP-0511 restriction for overhead area access, and inappropriately accessed the area without contacting health physics personnel to ensure appropriate radiological controls.

Corrective Action Taken and Results Achieved

Immediate corrective actions for this event included revoking the operators access to the RRA automated access control system to prevent entry into the RRA pending additional corrective action. The operator was counseled by operations and health physics supervision on the event, with emphasis on the requirements for working in a RRA. The Manager, Perry Nuclear Power Plant, Operations Section discussed the event with the operator to emphasize management expectations for compliance with requirements of the radiation protection program. Upon restoration of access to the RRA, the operator was assigned to accompany a health physics technician for one shift to further reinforce the radiation protection program requirements.

Actions to Avoid Further Violations

Radiation Protection Section supervision attended operations pre-shift briefings and discussed the event with operations personnel to re-emphasize the radiation protection program requirements for performance of work in overhead areas within the boundaries of the radiologically restricted area.

The Senior Operations Coordinator issued a standing instruction to prohibit the use of the access control radiation work permit for all operations personnel, and require use of the Operations general RWP for access to the RRA.

Date When Full Compliance Will Be Achieved

Full compliance was achieved on June 29, 1994 when the above corrective actions were completed.

Restatement of the Concern

Also, we are concerned with the high radiation dose that has been expended at your site during the refueling outage. Although your initial outage plans included appropriate radiological considerations such as partial chemical decontamination of the recirculation system and mock-up training for various high dose jobs, schedule pressure and other outage constraints appear to have led to management decisions during the outage which abrogated some of these plans and resulted in significant unnecessary dose. We are concerned that this may be an indication of a lack of management emphasis of the importance of minimizing overall dose expenditures during the outage. We understand that your review of outage activities will include an analysis of the outage management team's decision-making process to determine if the radiological consequences of their decisions were properly considered and, further, if management has clearly communicated an expectation for such consideration.

Response to Concern

The Perry Course of Action (PCA) recognizes that deficiencies have existed in the administration and enforcement of the radiation protection program including dose reduction practices and the plant work planning process. Further, senior management understands the need to expand the responsibility and accountability for dose beyond the Radiation Protection Section to the entire organization.

Action plans have been identified within the PCA to reduce unplanned personnel contamination events, reduce radioactive waste volume, improve the control of locked high radiation area doors, improve administration and enforcement of radiation protection controls, emphasize ALARA standards in radiation protection planning and improve the work planning process. In addition a meeting is scheduled for October 4, 1994, between Centerior management and the NRC to discuss dose reduction plans.

In accordance with Perry Administrative Procedure 0118, "ALARA Program", an ALARA Post Job Evaluation was performed on the recirculation system decontamination, the shipment of recirculation system components and undervessel work. These evaluations recognize the unnecessary dose expended due to inadequate planning, scheduling, and execution of the various work activities. Specific problems and recommended solutions have been identified for each job. These solutions will be included, as required, in the refuel outage evaluation and tracked to completion in preparation for the next refueling outage.